Washington State
Department of Social
& Health Services

Report to the Legislature

Annual Child Fatality Report
2004

RCW 74.13.640

Department of Social & Health Services
Children's Administration
Division of Children and Family Services/Office of Risk Management
PO Box 45040
Olympia, WA 98504-5040
(360) 902-7718
Fax: (360) 902-7903

Table of Contents

Executive Summary

In calendar year 2004, Washington State experienced the death of 746 children under the age of 18. Of these 746 deaths, 136 (18%) were reported to Children's Administration (CA). Child Fatalities are reported to CA when there are allegations or concerns about abuse or neglect, or when the fatality involved a CA client. Other, non-child abuse and neglect or case related, fatalities are sometimes reported to CA as well.

The following 2004 Child Fatality Report is a compilation of information regarding the deaths reported to CA. The analysis of this information is vital to the work of CA as a vehicle to assist CA staff, Tribes, providers, and community partners in improving the outcomes for the children and families we serve.

The fatalities reported to CA are divided into two categories: those that require a review and those that do not.

- Revised Code of Washington (RCW) 74.13.640 requires Child Fatality Reviews on unexpected child deaths, when: a) the family has history with CA within the last 12 months, b) the family has an open case at the time of death, or c) the child was residing or being cared for in a licensed or state operated facility at the time of death.

- Fatalities which do not require a fatality review include a) the fatality was without CA history within 12 months of the child's death, and b) those with no CA history, but the fatality was reported to CA.

In both of these groups we track the manner of death, age, gender, and race. Through the analysis of this data, we hope to identify children most at risk in order to inform and support a system that can improve the protection of children and reduce child fatalities related to abuse and neglect.

Of the 136 child fatalities reported to CA in 2004, 83 (61%) reported to CA met the criteria for a review.

In addition to the 2004 information, this report includes a comparison between the fatalities that occurred in 2003 and 2004.

There is also a section on near fatalities caused by abuse or neglect. Through reviewing fatalities and near-fatalities, CA receives an overall picture of the serious incidents that have occurred throughout the state. By documenting these in the Administrative Incident Reporting System (AIRS), statewide trends are identified.

Introduction

Child fatalities in the State of Washington are reviewed by two state agencies, the Department of Health (DOH) and Children's Administration within the Department of Social and Health Services (DSHS). These agencies have worked together to review child deaths since 1998.

DOH collects data on each child death in Washington in order to identify statewide trends and prevention strategies. While DOH has records of all child deaths, CA reviews the death of a child (RCW 74.13.640) when the death is unexpected and the child has history with CA within the last 12 months, has an open case at the time of death, or the child was residing or receiving services in a licensed or state operated facility at the time of death.

Fatalities are reported to CA when there are allegations or concerns about abuse or neglect, or for general notification purposes. Child Fatality Reviews examine all information provided to the department regarding the children and their families, including history and case activity.

The goal of the Child Fatality Review is to increase our understanding of the circumstances surrounding a child's death in order to evaluate CA practice, programs, and policies, and to evaluate other systems involved with the child, to improve the health and safety of children. From this review, areas needing improvement are identified and a work plan is developed to address any identified deficits in practice, policy, or systems.

CA's child fatality information is collected via several sources. These include CA's client database, Case and Management Information System (CAMIS), as well as the Administrative Incident Reporting System (AIRS), death certificates, and the regional Child Protective Services (CPS) Program Managers.

In 2004, the State of Washington had 746 child fatalities with 136 (18 %) reported to CA.[1] Of these, 83 (61%) fatalities met the requirements for a Child Fatality Review under CA policy. Fifty-three fatalities (39 %) had no history with CA or had history older than 12 months, which did not require a review, but were reported in the AIRS system. Statistical information on age, race, and gender regarding both sets of fatalities are included in this report.

[1] Data included in the tables and charts presented are based upon reports as of June 2006 and may change as new reports become available.

National Comparison

According to *Child Maltreatment 2004*, published by the Department of Health and Human Services (DHHS), "During 2004, an estimated 1,490 children died (compared to 1,460 children in 2003) from abuse or neglect—at a rate of 2.03 deaths per 100,000 children."[2]

In this same report, Washington State has a rate of 0.47 child fatalities per 100,000. Oregon and Idaho report fatality rates of 0.94 and 1.07, respectively. States with similar child populations as Washington, such as Arizona and Massachusetts, have rates of 1.49 and .82, respectively

Six states did not report their data on child fatalities. Excluding those states, Washington has the third lowest fatality rate per 100,000 children nationwide. Nevada is first with a 0.33 fatality per 100,000 and Rhode Island is second at .41 per 100,000

Washington State differs from the national data on child fatalities in several areas:

- Nationally, it is reported the older the child the lower the fatality rate. In Washington State, 40 percent of child fatalities are infants. There is a gradual decrease in the fatality rate for children four to 12. The fatality rate rises again between the ages of 13 and 18. The National data does not reflect this increase in adolescent fatalities.

- Nationally it is reported that the mother is the primary perpetrator of child homicides. In Washington (based on 2003 and 2004 homicide reports), the father is the primary perpetrator, followed closely by the mother.

- In the last two years, Washington has shown White as the racial group with the highest number of child fatalities. This group also has the highest number of child fatalities due to homicide. This is supported nationally. In Washington, the second highest racial groups in total child fatalities and in homicides are Native American and Hispanic. Nationally, the racial groups with the next highest number of fatalities are the Black or African American and Hispanic groups, in that order.

[2] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, *Child Maltreatment 2004* (Washington, DC: U.S. Government Printing Office, 2006).

2004 Child Fatalities Reported to Children's Administration

In 2004, 136 child fatalities were reported to CA. This includes those with and without previous involvement with the Children's Administration.

Manner of Death

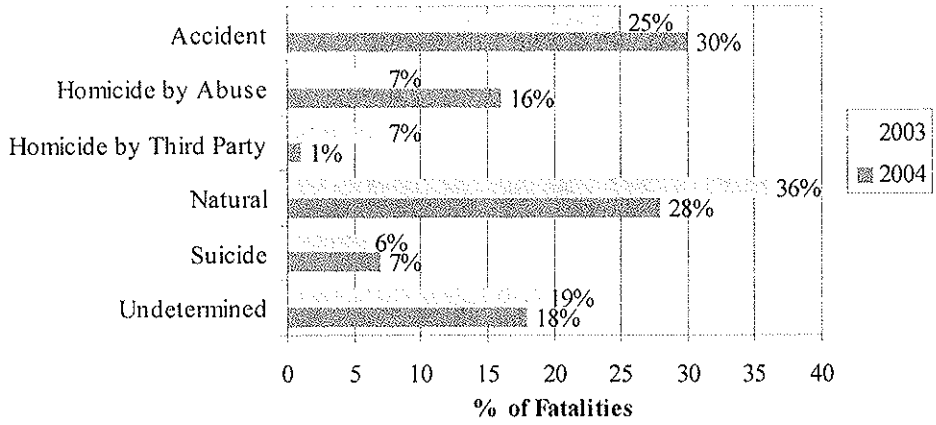
The manner of death is identified by local medical examiners and coroners.

Child Fatalities by Manner of Death

	2003		2004	
Accident	41	25%	40	30%
Homicide by Abuse	12	7%	22	16%
Homicide by Third Party	11	7%	2	1%
Natural	58	36%	37	28%
Suicide	10	6%	10	7%
Undetermined	30	19%	25	18%
Total	162	100%	136	100%

The one area that has significantly increased is homicide by abuse. Of the 22 identified homicides for 2004, nine (41%) had prior history with CA. Because the numbers of children represented in this sample is so low, the changes from 2003 – 2004 may not be statistically significant.

Child Fatalities by Manner of Death



Referrals Prior to Fatality

The table to the right displays the number of referrals regarding the child prior to the fatality. Prior referrals do not represent founded allegations of abuse or neglect that led to the child's death. Some referrals are not accepted for investigation due to the lack of allegations of abuse or neglect. Others may be the family requesting services.

Referrals Prior to Fatality

Prior Referrals	2003		2004	
	# of Fatalities	Percentage	# of Fatalities	Percentage
None	64	40%	42	30%
One	35	22%	26	19%
Two	16	10%	13	10%
Three	12	7%	12	9%
Four to Five	13	8%	13	10%
Six to Ten	10	6%	21	15%
> Ten	12	7%	9	7%
Total	162	100	136	100%

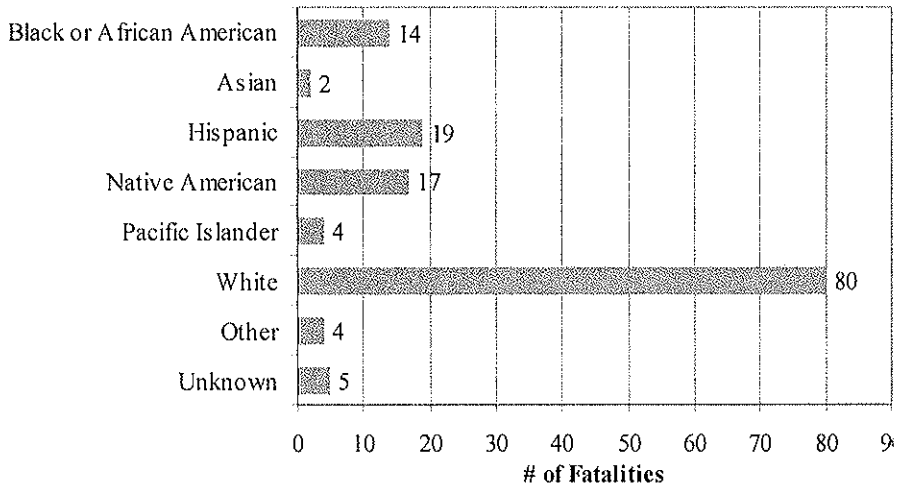
Forty-two (30%) of the 136 fatalities did not have any referrals prior to the fatality. Seventy percent of child fatalities reported to CA had at least one prior referral. Thirty-two percent had four or more referrals prior to the fatality.

2004 Total Child Fatalities by Race

Black or African American	14	10%
Asian	2	1%
Hispanic	19	13%
Native American	17	12%
Pacific Islander	4	3%
White	80	55%
Other	4	3%
Unknown	5	3%
Total	145*	100%

*Some children are in more than one category

2004 Total Child Fatalities by Race



Regional Fatality Reports

Children's Administration in the State of Washington is divided into six regions. Regional offices are located in the following cities:

- Region 1 – Spokane
- Region 2 – Yakima
- Region 3 – Everett
- Region 4 – Seattle
- Region 5 – Tacoma
- Region 6 – Tumwater

The following chart shows the number of fatalities reported to CA for each region across the state. To review regional charts by manner of death, see Appendix A.

2004 Child Fatalities – Regional Comparison

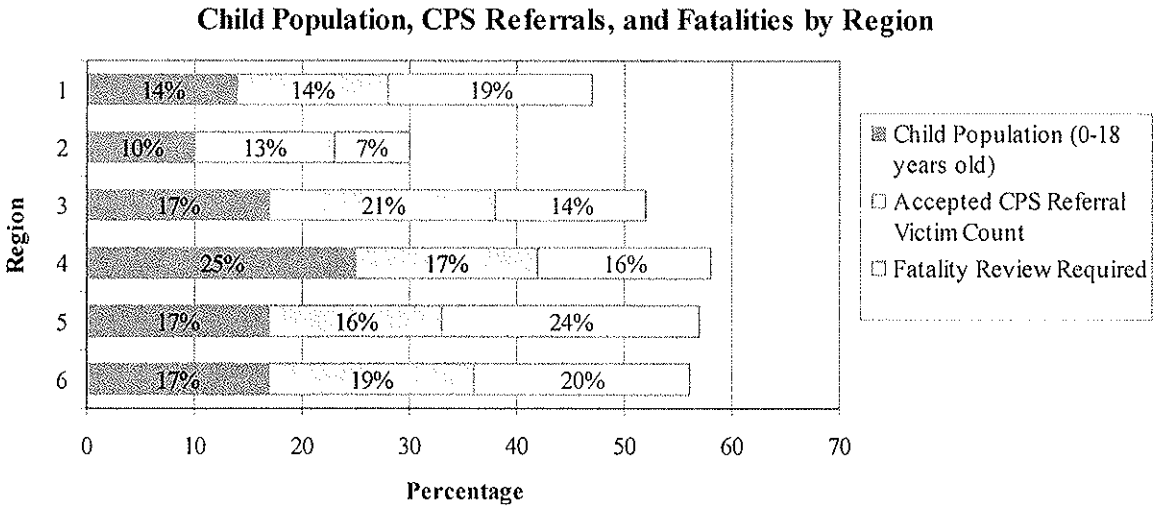
Region	Region Population[3]	Region Child (0-18) Population[4]	Accepted CPS Referrals[5]	Accepted CPS Referral Victim Count[6]	Total Fatalities Reported to CA	Fatality Review Required	No Fatality Review Required
1	810,128	208,016	5,620	8,314	22	16	6
2	561,674	156,336	4,952	7,680	14	6	8
3	1,029,988	253,628	7,211	11,584	20	12	8
4	1,777,143	389,035	6,843	10,105	19	13	6
5	984,549	252,257	6,019	8,974	37	19	18
6	1,040,306	250,508	7,338	11,175	24	17	7
Total	6,203,788	1,509,780	37,983	57,832	136	83	53

[3] Table 1: Annual Estimates of the Population of Counties for Washington: April 1, 2000 to July 1, 2004 (CO-EST2004-01-53) Source: Population Division, U.S. Census Bureau, Release Date: April 14, 2005.

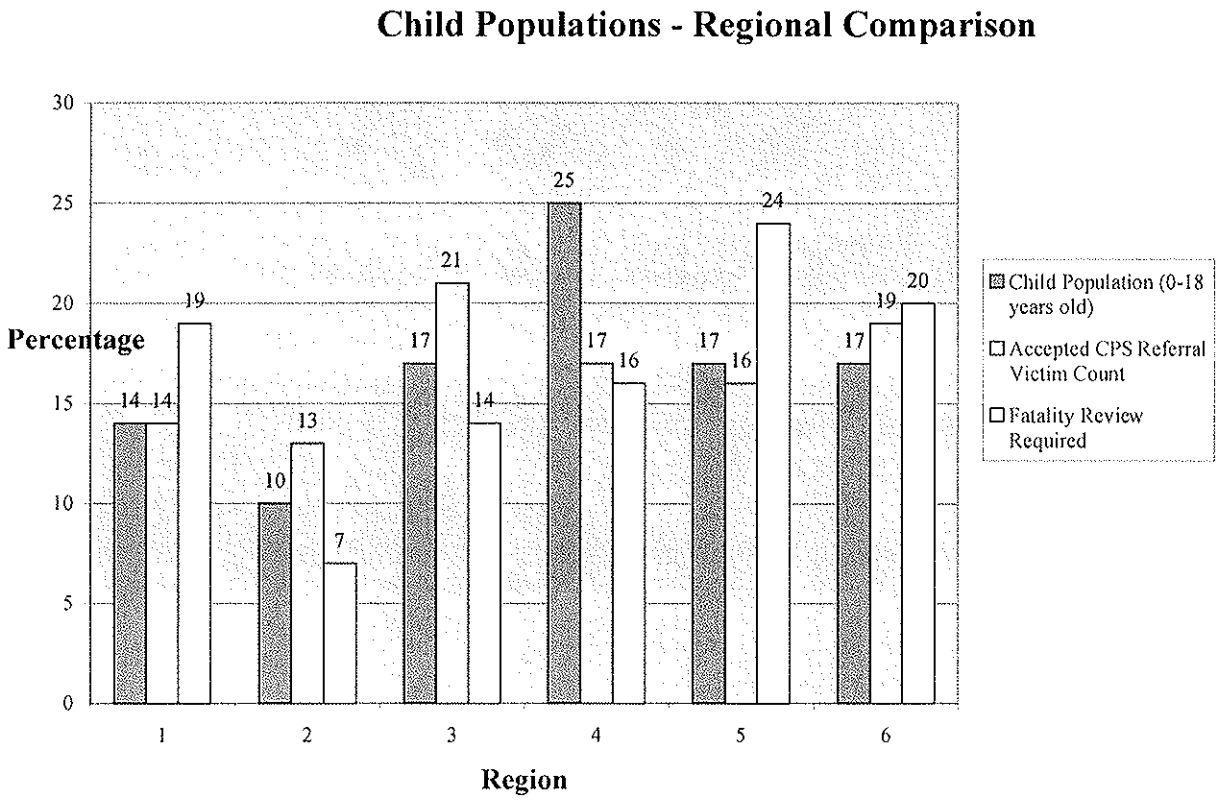
[4] Table 1: Annual Estimates of the Population of Counties for Washington: April 1, 2000 to July 1, 2004 (CO-EST2004-01-53) Source: Population Division, U.S. Census Bureau, Release Date: April 14, 2005.

[5] Case and Management Information System (CAMIS) Referral File, March 2005.

[6] CAMIS Referral File, March 2005.



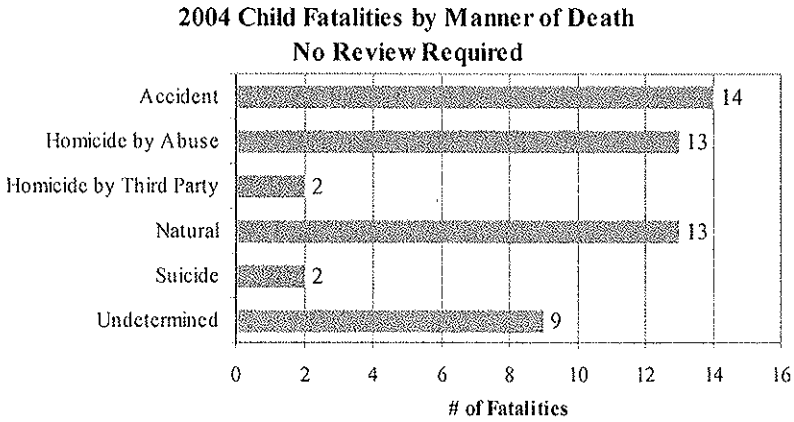
The chart below displays the child population, the number of victims identified in accepted CPS referrals, and the fatality reviews required for each region. This data is shown in percentages for to illustrate the distribution of each category across the state.



Child Fatalities – No Review Required

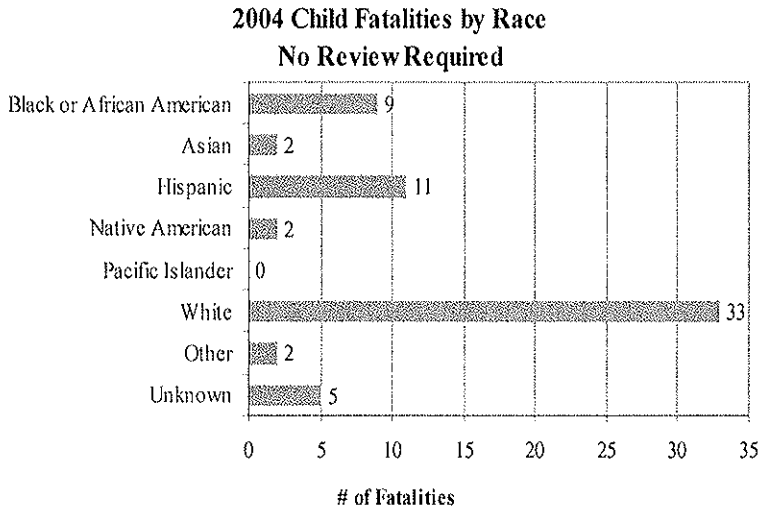
Of the 136 child fatalities reported to CA, 53 were identified as not having CA history within 12 months of death and did not involve CA clients. These fatalities did not require fatality reviews.

2004 Child Fatalities by Manner of Death - No Review Required		
Accident	14	25%
Homicide by Abuse	13	25%
Homicide by Third Party	2	4%
Natural	13	25%
Suicide	2	4%
Undetermined	9	17%
Total	53	100%



2004 Child Fatalities by Race - No Review Required		
Black or African American	9	14%
Asian	2	3%
Hispanic	11	17%
Native American	2	3%
Pacific Islander	0	0%
White	33	52%
Other	2	3%
Unknown	5	8%
Total	64	100

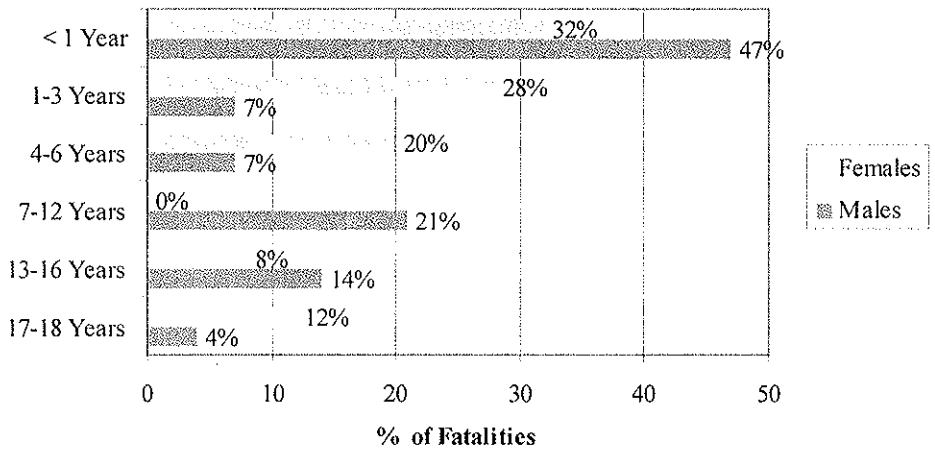
*Some children are in more than one category



2004 Child Fatalities by Age and Gender
No Review Required

Age	Males	% of Males by Gender	Females	% of Females by Gender	Age Totals	% by Age
< 1 Year	13	47%	8	32%	21	40%
1-3 Years	2	7%	7	28%	9	17%
4-6 Years	2	7%	5	20%	7	13%
7-12 Years	6	21%	0	0%	6	11%
13-16 Years	4	14%	2	8%	6	11%
17-18 Years	1	4%	3	12%	4	8%
Totals	28	100%	25	100%	53	100%

2004 Child Fatalities by Age and Gender
No Review Required



Homicide by Abuse

Among the 53 child fatalities that did not require a review by CA, 13 were identified as homicides by abuse. See the information below for information regarding these fatalities.

Cause of Death:

- Baseball bat
- Internal Injuries
- Shaken Baby Syndrome (4)
- Gun Shot (2)
- Burns (3)
- Head Injury (2)

Injury Inflicted by:

- Father (7)
- Mother (4)
- Childcare Provider (1)
- Unknown (1)

Child's Race:

- White (5)
- Hispanic (3)
- Hispanic & Black/ African American (3)
- Black/ African American (1)
- Unknown (1)

Child's Gender:

- Female (8)
- Male (5)

Age at Time of Death (average 2 years, 1 month):

- 3 months
- 4 months
- 6 months
- 1 year
- 1 year, 3 months
- 1 year, 9 months
- 1 year, 11 months
- 2 years
- 2 years, 1 month
- 2 years, 9 months
- 4 years (2)
- 5 years, 5 months

Number of Prior Referrals* per Child:

- No Prior History (10)
- Alternative Response history older than 12 months (2)
- Open case- child was placed in foster care after the injury that led to the fatality. The child lived for several years in foster care (1)

Region and office where fatality occurred:

- Region 3 – Everett
- Region 4 – Bellevue (2), Licensed Child Care, King Central
- Region 5- Bremerton, Tacoma
- Region 6- Kelso, Vancouver (2)

*Prior referrals do not mean the allegations were founded for Child Abuse and Neglect (CA/N).

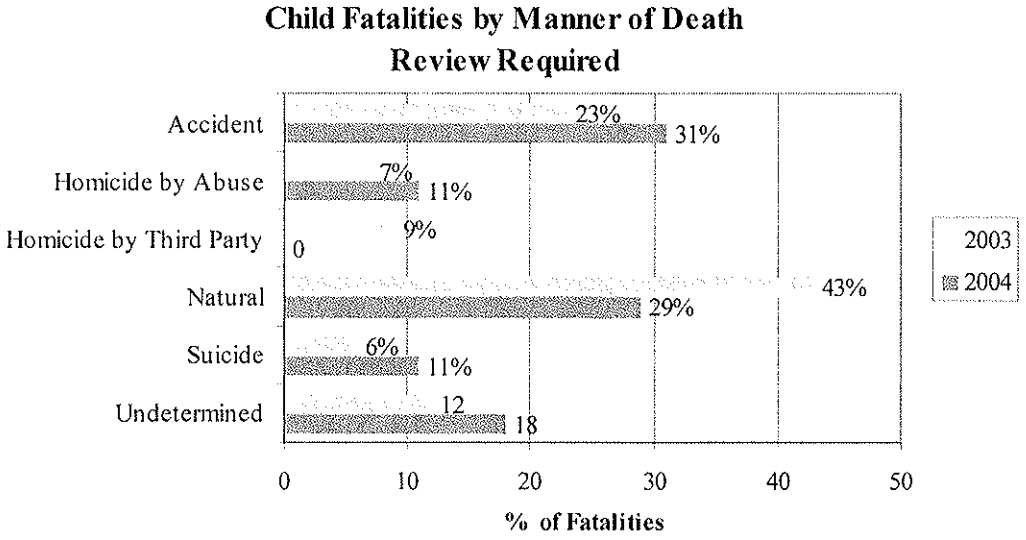
Child Fatalities – Review Required

In calendar year 2004, 83 fatalities required a fatality review. These fatalities had an open case at the time of the fatality, had history within 12 months, or the child died while in licensed care. The following charts reflect the manner of death, age, gender, and race.

Below is a manner of death comparison between 2003 and 2004. The largest increase occurred in the number of accidents (8%). Homicide by abuse increased by four percent (3 children) in 2004.

Child Fatalities by Manner of Death – Review Required

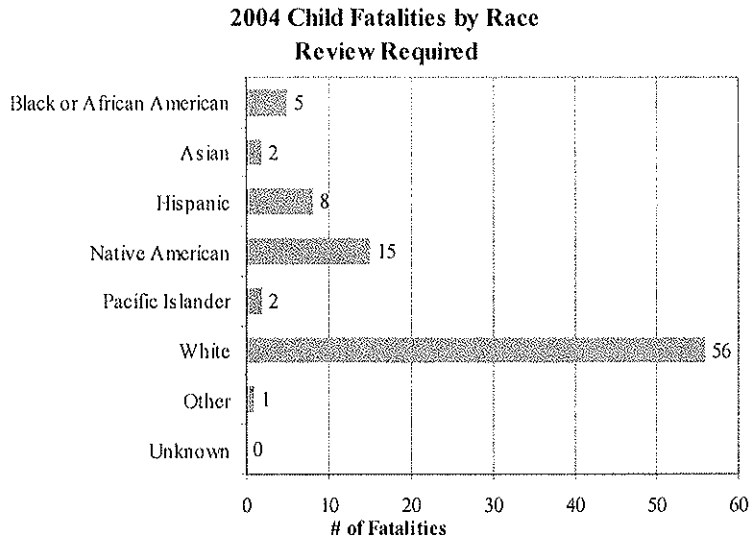
	2003		2004	
Accident	21	23%	26	31%
Homicide by Abuse	6	7%	9	11%
Homicide by Third Party	8	9%	0	0%
Natural	39	43%	24	29%
Suicide	5	6%	9	11%
Undetermined	11	12%	15	18%
Total	90	100%	83	100%



2004 Child Fatalities by Race - Review Required

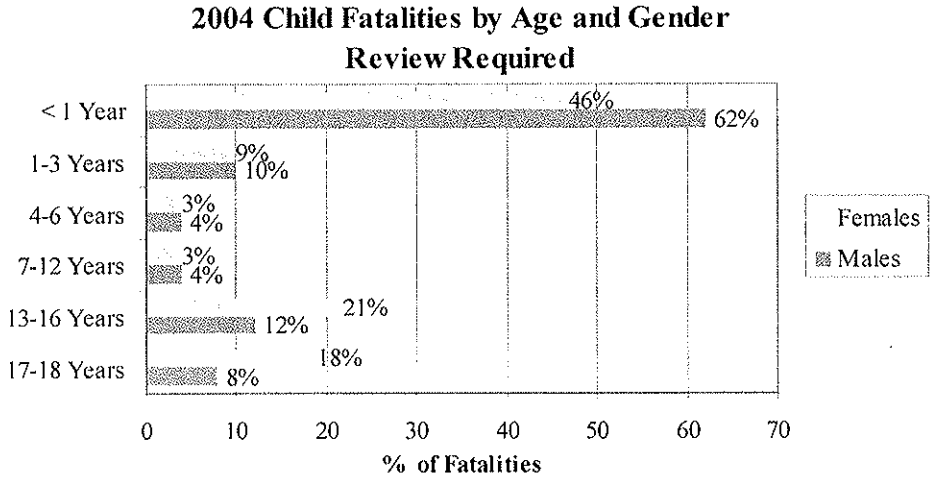
Black or African American	5	6%
Asian	2	2%
Hispanic	8	9%
Native American	15	17%
Pacific Islander	2	2%
White	56	63%
Other	1	1%
Unknown	0	0%
Total	89	100

*Some children are in more than one category



2004 Child Fatalities by Age and Gender Review Required

Age	Males	% of Males by Gender	Females	% of Females by Gender	Age Totals	% by Age
< 1 Year	31	62%	15	46%	46	54%
1-3 Years	5	10%	3	9%	8	10%
4-6 Years	2	4%	1	3%	3	4%
7-12 Years	2	4%	1	3%	3	4%
13-16 Years	6	12%	7	21%	13	16%
17-18 Years	4	8%	6	18%	10	12%
Totals	50	100%	33	100%	83	100%



Homicide by Abuse – Review Required

Nine of these 83 fatalities were due to homicide by abuse. See below for additional information regarding these fatalities.

The causes of death were:
- Domestic violence
- Head butt and sock in child's mouth
- Blunt force trauma
- Gun shot
- Shaken baby
- Child pushed
- Neglect (2)
- Skull Fracture

Age at time of death (average 17.4 months):
- 2 months (3)
- 3 months
- 9 months
- 1 year 4 months
- 2 years
- 2 years 10 months
- 5 years 5 months

Race:
- White – 4
- Native American – 2
- Native American/White – 2
- Black or African American – 1

Gender:
- Male – 6
- Female – 3

Number of prior referrals*:
- 4 children had 1 prior referral
- 2 children had 5 prior referrals
- 2 children had 6 prior referrals
- 1 child was in licensed care

Region and office where fatality occurred:
- Region 1 – Spokane (2)
- Region 3 – Oak Harbor, Sky Valley, Smokey Point
- Region 5 – Bremerton (2), Tacoma
- Region 6 – Vancouver

The nine perpetrators of child homicide by abuse had the following characteristics:

Prior Criminal history:
- Yes – 7
- No – 2

Prior CPS history* (either as an adult or child):
- Yes – 7
- No – 2

Injury inflicted by:
- Mother – 3
- Father – 2
- Mother and Father – 1
- Boyfriend – 2
- Grandfather – 1

*Prior referrals do not mean the allegations were founded for Child Abuse and Neglect (CA/N).

Trends
1997 – 2004

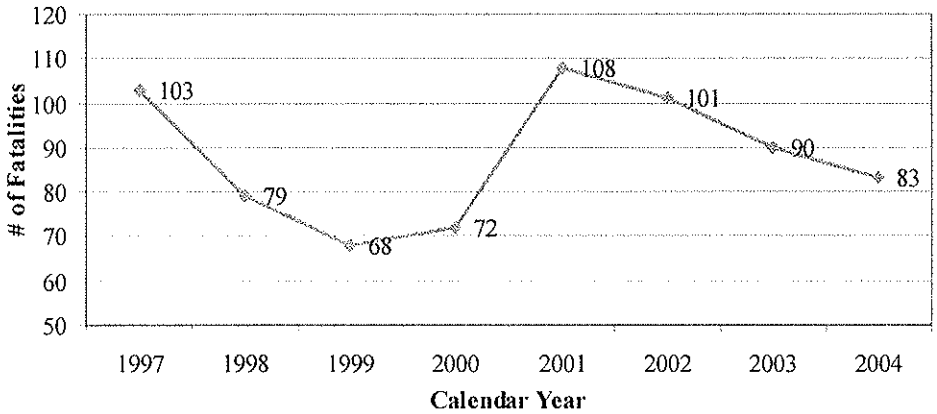
How does the number of child fatalities this year compare with last year? This is the most commonly asked question CA receives regarding fatalities. The table below displays the number of fatalities requiring a Child Fatality Review from 1997 through 2004 by manner of death. The average number of fatalities over these eight years is 88.

Children's Administration Statewide Child Fatality Data
Child Fatalities Meeting the Criteria for an Internal Child Fatality Review
Calendar Years 1997 – 2004*

Manner of Death	1997	1998	1999	2000	2001	2002	2003	2004
Accident	36	20	20	21	26	32	21	26
Homicide by Abuse	6	9	4	8	3	7	6	9
Homicide by Third Party	10	5	5	2	8	5	8	0
Natural	45	39	33	33	61	47	39	24
Suicide	5	2	2	5	5	3	5	9
Undetermined	1	4	4	3	5	7	11	15
Total	103	79	68	72	108	101	90	83

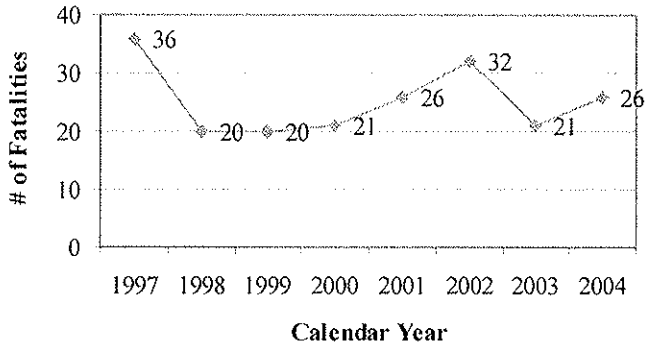
*Data included in this table is based upon information as of May 2006 and may change as new information becomes available.

Child Fatalities Requiring a Review
1997 - 2004

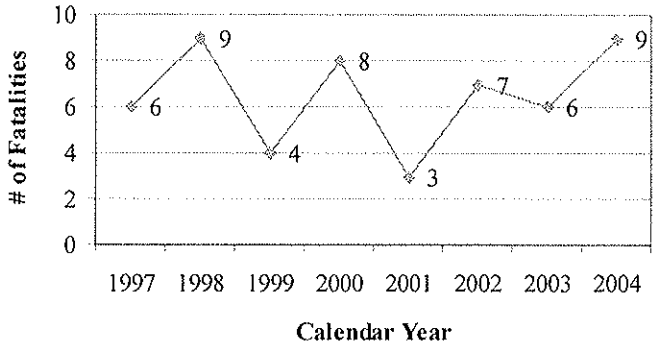


The following charts display the manner of death from 1997 to 2004. The number of undetermined deaths has increased over the last eight years. This is due to the manner in which Sudden Infant Death Syndrome (SIDS) is classified. SIDS was previously classified as a natural manner of death. However, recently SIDS is defined as the exclusion of all causes of death, thus placing these fatalities into the undetermined category. As medical examiners and coroners become trained to this, the manner of death determination will change.

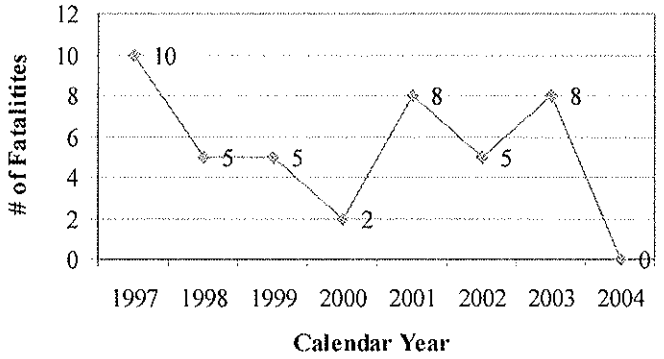
Child Fatalities - Accident
1997 - 2004



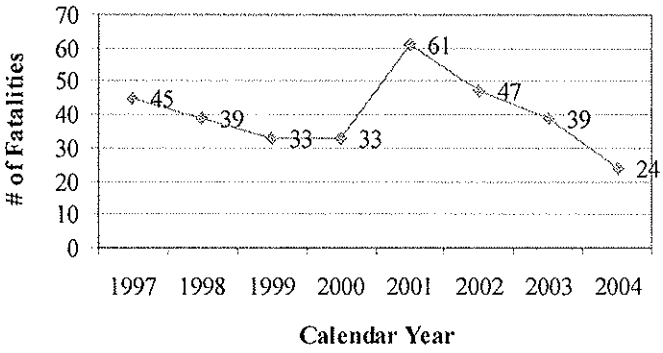
Child Fatalities - Homicide by Abuse
1997 - 2004



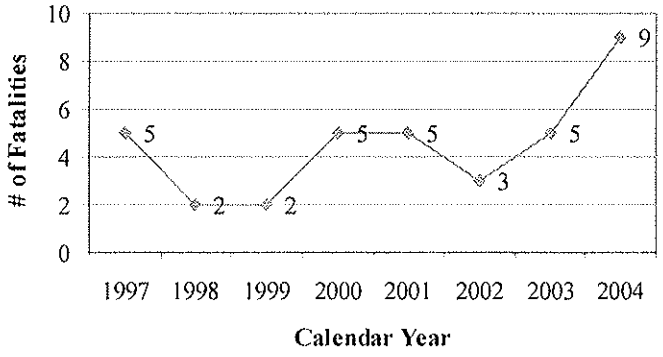
Child Fatalities - Homicide by Third Party
1997 - 2004



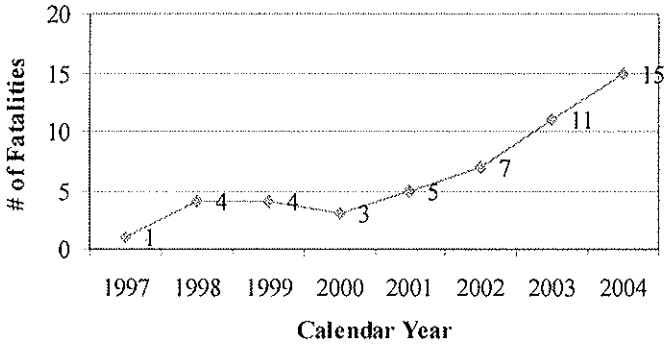
Child Fatalities - Natural
1997 - 2004



Child Fatalities - Sucide
1997 - 2004



Child Fatalities - Undetermined
1997 - 2004



Child Fatalities by Neglect

As with most states across the nation,[7] Washington State relies on medical examiners and coroners to determine the cause and manner of death of a child. The decision to follow this classification system has led to an underreporting of child maltreatment fatalities nationwide.[8] "In the United States, existing numbers of child fatalities have been shown to grossly underestimate the actual number of children dying from maltreatment."[9]

Reports alleging abuse and neglect of children are received by CA everyday. Each report is assessed and a determination is made whether or not a social worker will investigate the allegation. Once the social worker investigates the allegation, a finding is made. Findings can be founded, unfounded, or inconclusive. A founded allegation is required to be supported by facts known to the department when the investigation is complete.

Washington Administrative code 388.15.009(5) defines negligent treatment or maltreatment as:

> "Negligent treatment or maltreatment means an act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, and safety. Negligent treatment or maltreatment includes, but is not limited, to:
>
> (a) Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, and safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;
>
> (b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or
>
> (c) The cumulative effects of consistent inaction or behavior by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child."

---

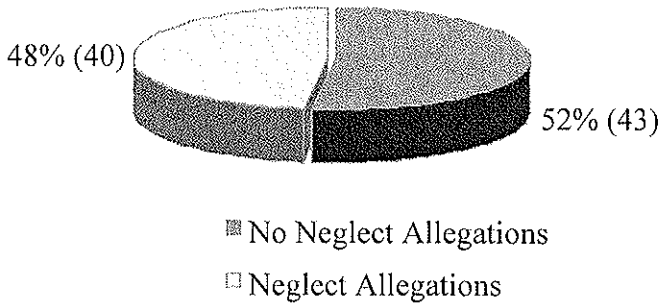
[7] Crume, TL, DiGuiseppi C, Byers T, et al. Underascertainment of child maltreatment fatalities by death certificates, 1990-1998. *Pediatrics* 2002; 110(2 pt 1):e18.

[8] Herman-Giddens ME, Brown G, Verbiest S, et al. Underascertainment of child abuse mortality in the United States. JAMA 199;282:463-7.

[9] Jenny C., Isaac, R.. The relation between child death and child maltreatment. Arch Dis. Child. 2006;91;265-269.

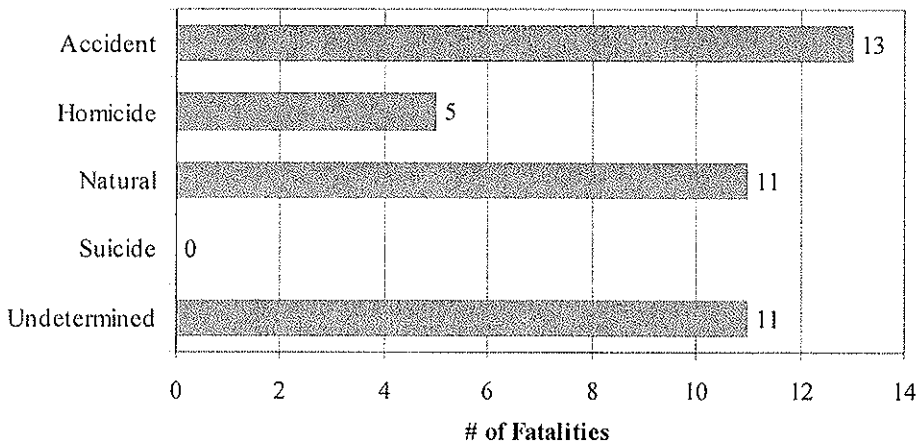
The remainder of this section provides detailed information about neglect factors as they relate to the child fatalities that required a review in 2004. Of the 83 cases requiring a review, neglect allegations were identified in 40 cases.

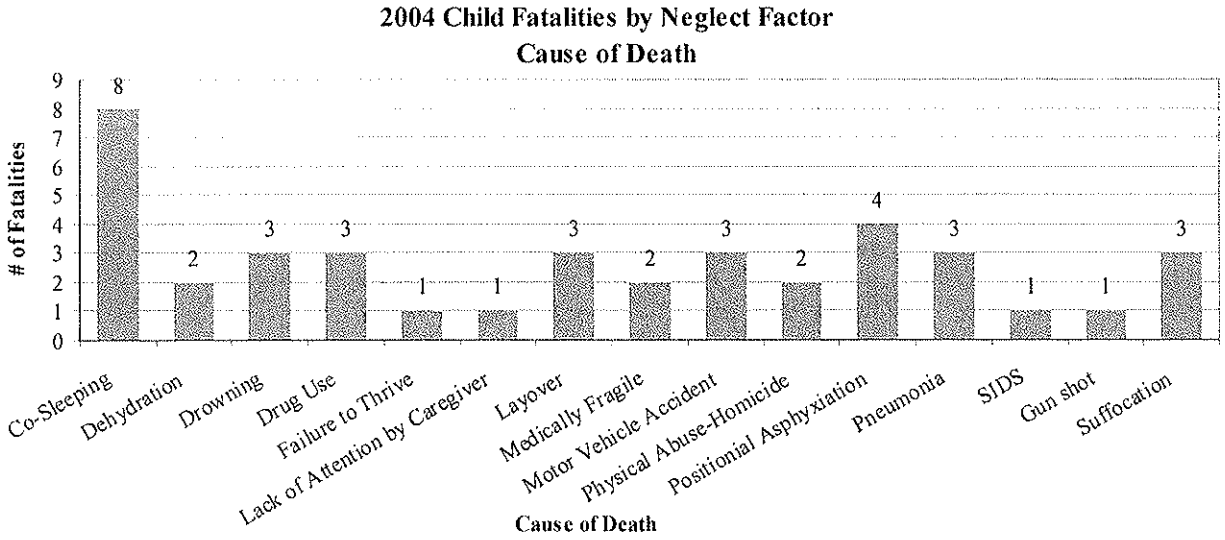
2004 Child Fatalities - Neglect Factors

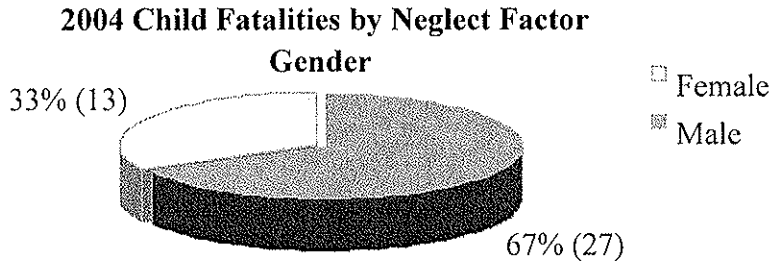


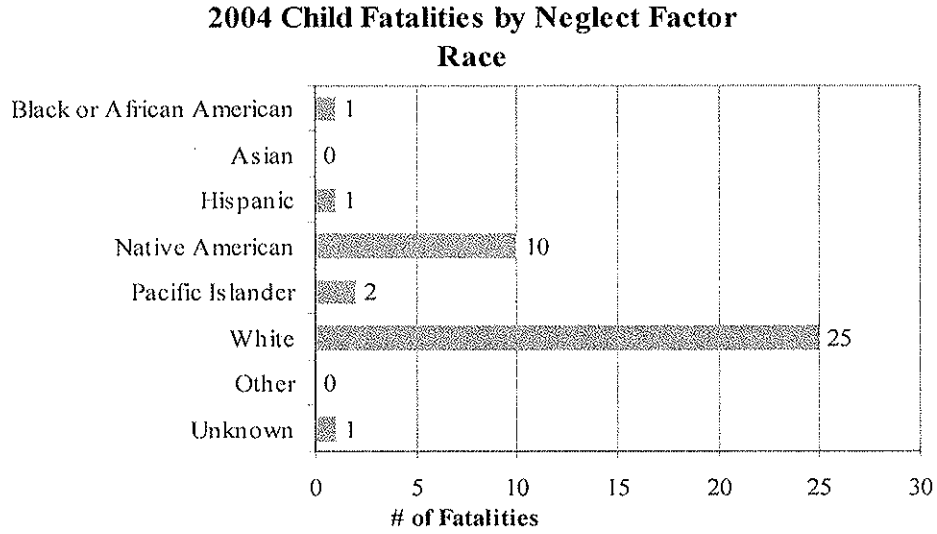
Medical examiners and coroners classify fatalities in different ways, especially when neglect is a factor. The following chart reflects these different classifications. Notice the number of undetermined and accidental fatalities when neglect is alleged.

2004 Child Fatalities by Neglect Factor
Manner of Death

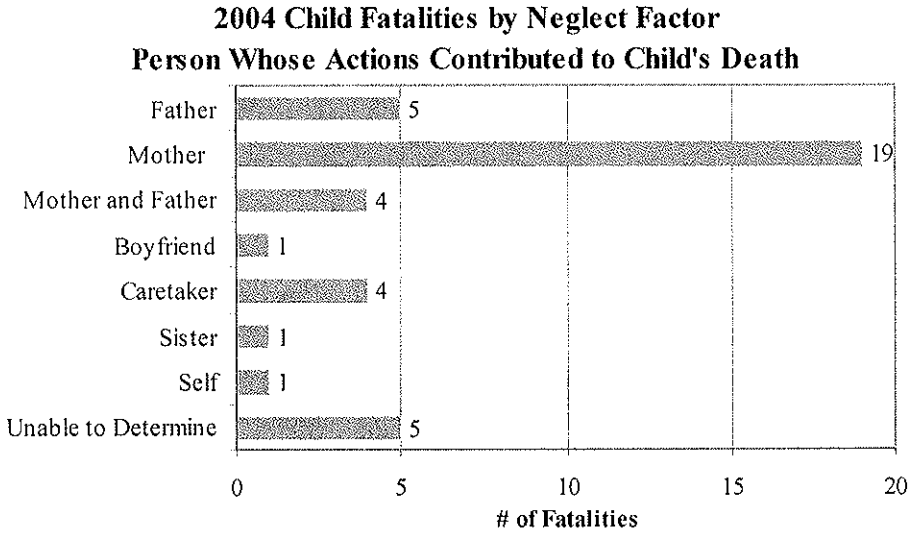


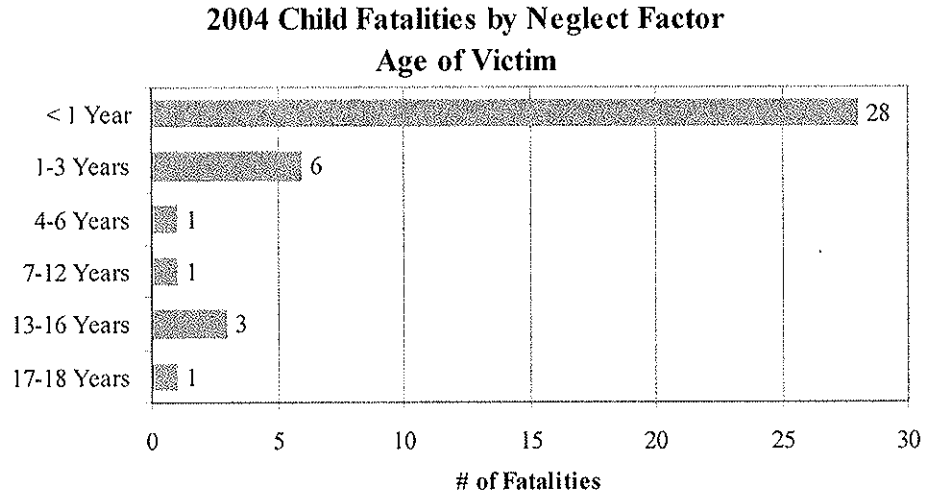

2004 Child Fatalities by Neglect Factor
Cause of Death
# of Fatalities
Cause of Death
Co-Sleeping
Dehydration
Drowning
Drug Use
Failure to Thrive
Lack of Attention by Caregiver
Layover
Medically Fragile
Motor Vehicle Accident
Physical Abuse-Homicide
Positional Asphyxiation
Pneumonia
SIDS
Gun shot
Suffocation


2004 Child Fatalities by Neglect Factor
Gender
33% (13)
67% (27)
Female
Male


2004 Child Fatalities by Neglect Factor
Race
Black or African American
Asian
Hispanic
Native American
Pacific Islander
White
Other
Unknown
# of Fatalities

The chart to the right identifies the individual whose actions contributed to the child's death. It is important to note that most neglect fatalities are acts of omission. The case that exemplifies this type of fatality is the deaths of Justice and Raiden Robinson. The mother was incapacitated by alcohol consumption and the children died of dehydration and malnutrition.





Drugs and/or alcohol were involved in 18 of the 40 deaths with neglect factors.

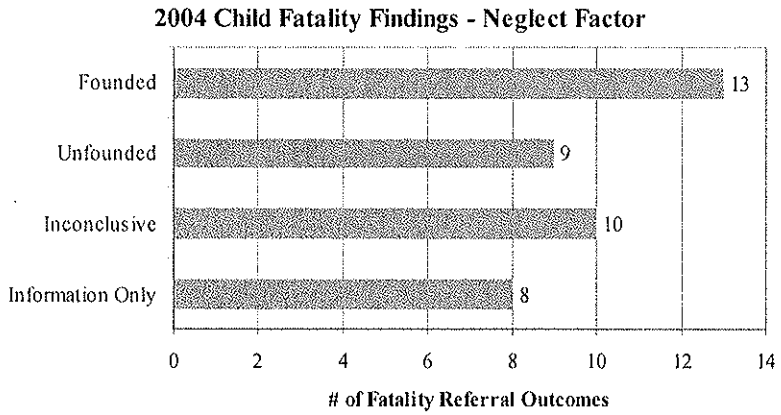
- Alcohol – 5
- Cocaine – 3
- Methamphetamine – 3
- Marijuana – 1
- Methamphetamine and Marijuana – 1
- Methamphetamine and Alcohol – 1
- Marijuana and Alcohol – 1
- Cocaine and Alcohol – 1
- Alcohol and Poly Substance – 1
- Prescription Drugs – 1

Co-sleeping, layover, suffocation, and positional asphyxiation are four causes of death associated with sleeping. It is often asked if there is a relationship between caregiver drug use and causes of death in these sleep related fatalities.

- Of eight children co-sleeping at time of death, five cases alleged the parent was actively involved with drug use at the time of the child's death.
- For the three children whose death was due to layover, one had alleged alcohol and one had alleged alcohol/drug activity occurring in the home at the time of death.
- Regarding the three children who suffocated, two had alleged active drug use in the home at the time of the death.

Fifty-six percent of child fatalities associated with sleeping occur when there is active drug use in the home.

When CA learns of a child fatality, a referral is created. A finding of founded, unfounded, or inconclusive is made following an investigation by the assigned social worker. The chart to the right displays the findings of the referrals regarding the fatalities that involved neglect. "Information Only" referrals are not assigned for investigation; therefore, no findings are made.



Five homicides had allegations of neglect. Of these five, four were founded and one was inconclusive. If those founded for neglect were combined with the homicide by abuse deaths, the total would be eighteen fatalities. **Therefore, 22 percent of the 83 fatalities requiring a review would have been classified as a fatality caused by abuse or neglect.**

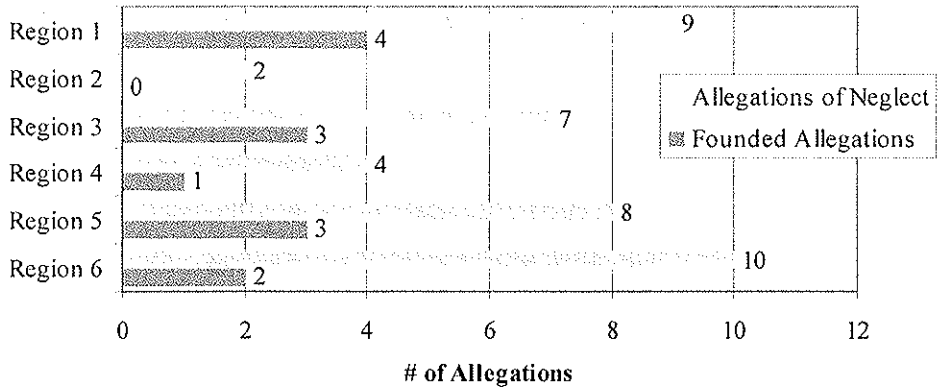
2004 Child Fatalities with Neglect Allegations by Manner of Death

Manner of Death	Accident	Homicide	Homicide by Third Party	Natural	Suicide	Unknown	Total
Founded	5	4	0	3	0	1	13
Unfounded	2	0	0	5	0	2	9
Inconclusive	1	1	0	2	0	6	10
Information Only	5	0	0	0	0	3	8
Total	13	5	0	10	0	12	40

Of the 13 cases founded for neglect:

- 8 had prior information only referrals
- 9 had prior accepted CPS referrals
- 2 were licensed daycare cases
- There were an average of 4.08 CPS referrals per case

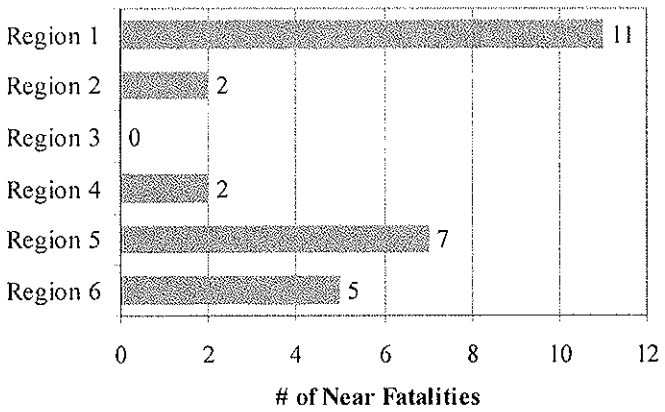
2004 Child Fatalities with Neglect Allegations by Region



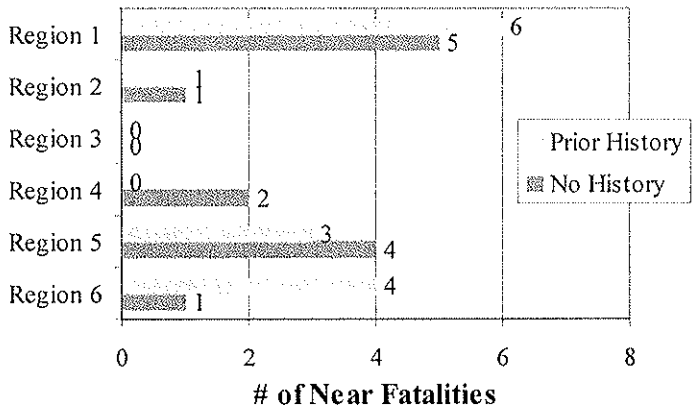
Near Fatalities - Child Abuse and Neglect

In an attempt to review all serious incidents of child abuse and neglect, this report also looks at near fatalities. A near fatality is defined as an injury or condition where the child is in serious or critical condition (RCW 74.13.500). Twenty-seven near fatalities were reported to CA in 2004. CA documents all near fatalities through the AIRS system. These incidents are classified as being caused by abuse or neglect. These incidents are reviewed by Children's Administration Office of Risk Management and regional CPS program managers.

2004 Near Fatalities by Region



2004 Near Fatalities with CA History



Fourteen near fatality cases occurred in a licensed facility or had prior history with CA. The average age of these children is four years and four months.

2004 Near Fatalities with CA History

Age	Gender	Race	Prior Referrals	Cause of Injury
		Region 1		
16 years	Female	Native American	4	Neglect
11 months	Female	Hispanic	1	Shaken Baby
4 months	Male	Black or African American	8	Shaken Baby
3 months	Male	Hispanic	8	Shaken Baby
2 months	Male	White	3	Shaken Baby
1 months	Male	Native American	4	Broken Bone
		Region 2		
8 months	Female	Unknown	0	Licensing--Accidental
		Region 5		
6 years	Male	White	18	Neglect
3 years	Male	Pacific Islander	3	Neglect
1 years	Female	White	3	Neglect
		Region 6		
16 years	Female	Native American	23 bio-family	Car Accident–Relative Placement
13 years	Female	White	22 bio-family	Overdose–Foster Care
7 years	Male	White	17 bio-family	Train Accident–Relative Placement
1 years	Male	Native American	3 bio-family	Near Drowning–Foster Care

Policy Changes and Fatality Reviews

CA reviews child fatalities to improve service delivery to children and families.

Of the 83 child fatalities reviewed, 45 (54%) had issues and recommendations identified during the fatality review process. Issues and recommendations from fatality reviews impact policy, practice, and systems associated with CA.

The first column below identifies CA issues. The second column indicates how many of the issues required a work plan to address the identified issue.

Issues Identified		Work Plan Needed
14	Policy issues	5 Policy issues
117	Practice issues	26 Practice issues
31	System issues	8 System issues
9	Quality social work	**39 Total**
10	Contract issues	
172	**Total**	

Both regional and statewide issues required work plans in 2004. There are also issues that require attention at a local office level. For example, one policy issue states, "Social worker needs to complete the Investigative Risk Assessment for this referral." This item is a practice issue that requires the social worker and supervisor to address the issue.

The following are samples of fatality review issues and recommendations:

- When a firearm is on the premises of a licensed foster home, the licensor will review a specific policy statement with the foster parents and obtain their signatures. (policy issue)

- Training is needed for social work staff to address substance abuse. Currently, CA offers mandatory training on substance abuse issues. (practice and system issue)

- Training is needed to address domestic violence. There is a workgroup addressing CA's response to domestic violence. Once a statewide policy is developed, training for staff will be completed to implement the policy. (practice and system issue)

- Training is needed to improve documentation of case activity and all assessments. (practice issue)

- Investigation of allegations needs to be addressed to improve the basic approach to investigations. (practice issue)

- It is indicated that there are issues regarding transfer of cases between regions. This is currently being addressed in the revision of the practice model which will facilitate better coordination between regions. (practice issue)

- There is a recommendation to improve the agency response to traumatic events and workload issues statewide. There currently is a work group addressing these issues. The work group is developing a statewide policy that will address traumatic events and CA response protocols to these events. The legislature has approved new social work positions which will reduce the workload issues across the state. (practice issue)

- Access to local, county, state, and national database systems that record individual's criminal activity is needed. (system issue)

- Social service systems lack of resources to adequately provide substance abuse and mental health services for families we serve. (system issue)

For additional examples of fatality review issues and recommendations, please see the Justice and Raiden Robinson Child Fatality Review recommendations with the current status of how CA is addressing these issues at http://www1.dshs.wa.gov/pdf/ea/govrel/Leg0306/CAFatality1205.pdf (reports #04-51 and #04-52).

Issues identified in these reviews have an impact on practice in the field. The following are examples of improvements made based on recommendations from fatality review teams:

- Child Protective Services (CPS)/Child Welfare Services (CWS) redesign. This will define when a case is transferred from CPS to CWS. This will separate the investigation and assessment services from the voluntary and court services.

- Training for law enforcement on issues pertaining to child abuse.

- Reunification with non-custodial parents requires a full assessment prior to the placement of a child in the care and custody of the non-custodial parent.

- Consultation with CA contracted medical consultation providers when a child's injuries are serious.

- Increased case collaboration between professionals.

- Retraining of all social work staff and their supervisors on investigations and risk to a child.

- Training on bias and critical thinking.

- Holding workers and supervisors accountable when they fail to follow protocols or policy.

- Memorandum of Understanding (MOU) with DASA (Division of Alcohol and Substance Abuse) regarding shared cases.

Key Terms

Administrative Incident Reporting System (AIRS): AIRS is a relatively new system for CA. Usage began in 2002 in pilot sites in Region 2 (Yakima and the surrounding areas) and Region 5 (Pierce/Kitsap County area). All regions were instructed to use this system for fatality reports during 2003. After successful results, AIRS was fully implemented statewide on January 1, 2005. This s ystem was designed to track child fatalities, near fatalities, and other critical incidents and has eliminated the need for several different reporting formats. Information from AIRS is used to identify incident patterns, trends, and systems issues to determine what interventions are needed to improve the health, safety, and well-being of the children and families in Washington State.

Cause of death: "Cause of death is the disease or injury" that was responsible for the death or the death events as defined by the American Family Physician. Examples of cause of death include cancer, pneumonia, blunt trauma, Sudden Infant Death Syndrome (SIDS), and poisoning.

Co-sleeping: A cause of death described as sleeping together with parents or with other children in the same location.

Layover: A cause of death described as a child who is laid on by another person or animal.

Manner of death: categorized into the following groups *natural*, *accident*, *suicide*, *homicide*, and *undetermined.* Manner of death does not indicate cause and effect, but is used in conjunction with the cause of death to better describe how the death occurred.[10] The manner of death category is identified by the local medical examiners and coroners.

Manner of death and cause of death relationship: The cause of death describes what physically caused the death while manner of death refers to the intention that led to the death. For example, when a person dies from a cocaine overdose, the manner of death could be listed as an accident and the cause of death listed as an overdose of cocaine. In this case, even though the person was engaging in a dangerous activity, it is classified as an accident because the person did not intend to harm himself or herself.

Neglect: "An act or a failure to act on the part of a child's parent, legal custodian, guardian, or caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, and safety. Negligent treatment or maltreatment includes, but is not limited, to:

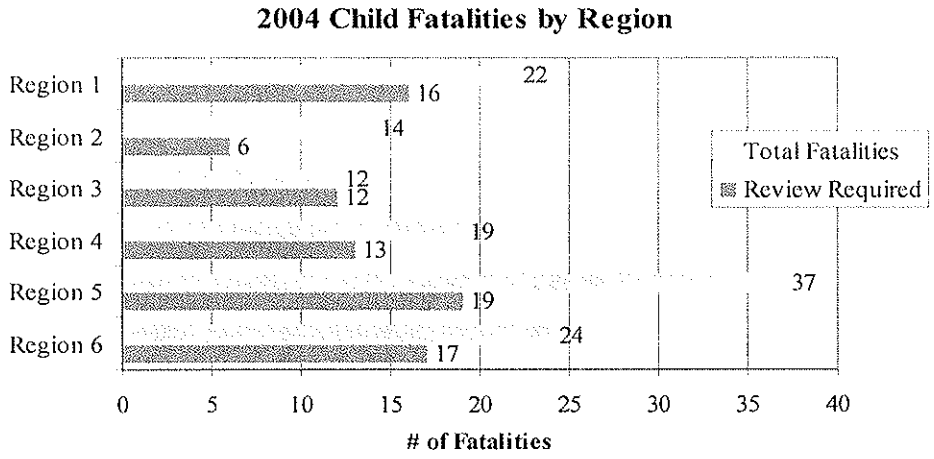
[10] American Family Physician, October 1, 1997, Volume 56, Number 5.

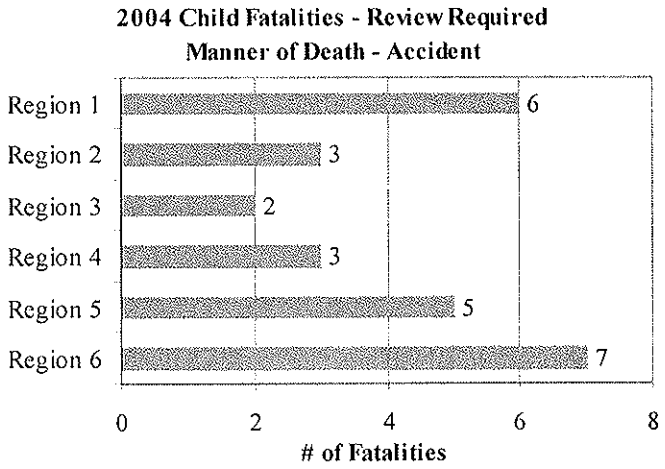
1. Failure to provide adequate food, shelter, clothing, supervision, or health care necessary for a child's health, welfare, and safety. Poverty and/or homelessness do not constitute negligent treatment or maltreatment in and of themselves;
2. Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child; or
3. The cumulative effects of consistent inaction or behavior by a parent or guardian in providing for the physical, emotional and developmental needs of a child's, or the effects of chronic failure on the part of a parent or guardian to perform basic parental functions, obligations, and duties, when the result is to cause injury or create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child.

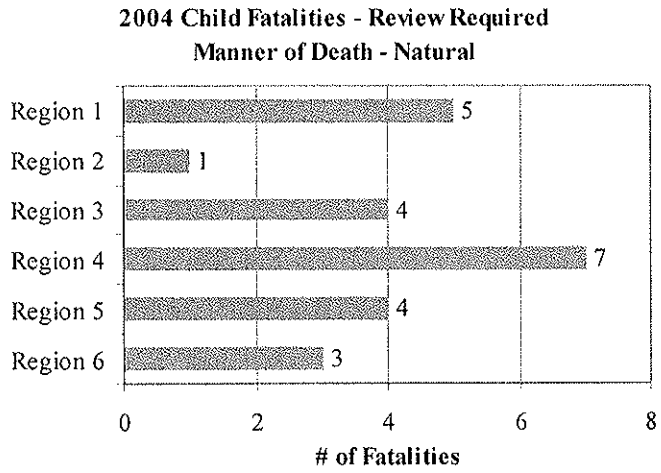
Positional Asphyxiation: A cause of death described by a deprivation of oxygen due to the position of the child.

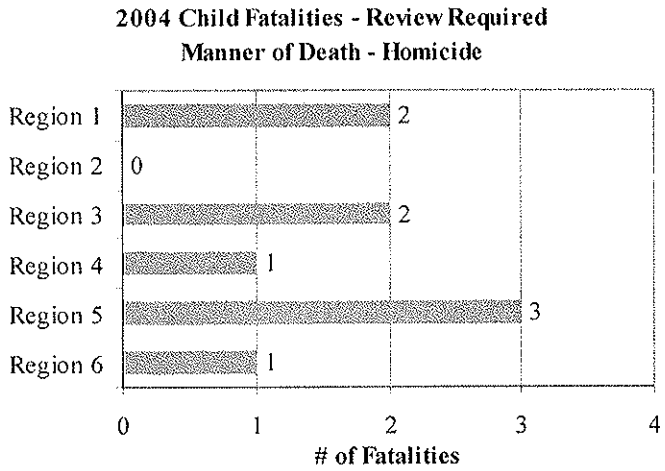
APPENDIX B

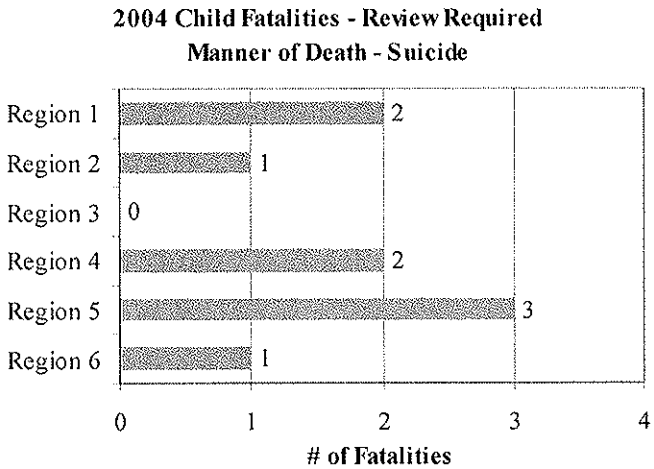
Regional Tables and Charts



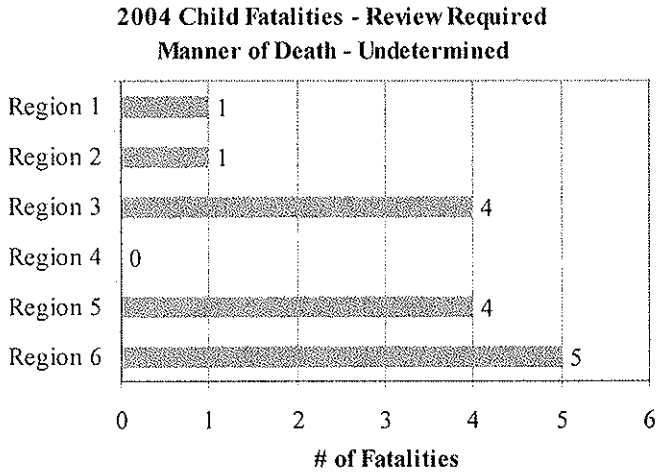








APPENDIX B


2004 Child Fatalities - Review Required
Manner of Death - Undetermined
Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
1
1
4
0
4
5
0
1
2
3
4
5
6
# of Fatalities

APPENDIX C

Characteristics of Homicide by Abuse – 2004

Child (Average Age 17.4 months)	Female 2 months	Male 2 months	Male 2 months	Male 3 months	Male 9 months	Male 16 months	Female 2 years	Female 2 years 10 months	Male 5 years 5 months
Race/Ethnicity	Native American	White	Native American	White	Native American	Native American	White	Black or African American	White
Cause of Death	DV—pushed pregnant mother out of car	Head butt, sock in mouth	Neglect—dehydration	Skull fracture	Shaken baby	Neglect—dehydration	Child pushed	Blunt trauma to head	Shot
Role of Person Responsible for Cause of Death	Father	Father	Mother	Mother	Boyfriend of caretaker	Mother	Boyfriend of mother	Father + mother	Grandfather
Age of Person Responsible for Death (average 29.7 years)	20	20	37	21	22	37	24	27+30	59
Primary Caretaker was Unrelated to the Child	No	No	No	No	Yes	No	Yes	No	No
Primary Caretaker had Limited Bonding/Attachment to the Child	Yes	Yes	No	No	Yes	No	Yes	No	No
Primary Caretaker was Using Drugs	Yes	No	Alcohol	Yes	Yes	Alcohol	Yes	Yes	No

APPENDIX C

Child (Average Age 17.4 months)	Female 2 months	Male 2 months	Male 2 months	Male 3 months	Male 9 months	Male 16 months	Female 2 years	Female 2 years 10 months	Male 5 years 5 months
Primary Caretaker had Allegations of Physical Abuse Against Them Prior to Death of Child	History of violence and anger	Yes	No	No	Family history of physical abuse, current history with LE	No	No	Yes	No
Primary Caretaker had Mental Health Issues Identified by a Professional	Anger issues	Yes	Yes	Yes	No	Yes	No	No	No
Sex of Person Inflicting Injury that Caused Death	Male	Male	Female	Female	Male	Female	Male	Male + female	Male
Prior CPS History of Person Inflicting Injury—Either as Child or Adult	Mother had history as child PA + SA	Yes--extensive history	Prior CPS history as adult	Yes	Family history as child	Prior CPS history as adult	No	Yes	No
Prior Criminal History of Person that Caused Death	Yes	Yes--DV	Yes--DV	Yes	Yes	Yes--DV	No	Yes	No

* DV=domestic violence, BF=boyfriend, MJ=marijuana, meth=methamphetamine, PA=physical abuse, SA=sexual abuse, LE=Law enforcement

APPENDIX D

Child Fatality Charts

2004 Total Child Fatalities by Age and Gender
Manner of Death

Age	Accident	Homicide by Third Party	Homicide by Abuse	Natural	Suicide	Undetermined
Up to 1 Year	8	0	9	30	0	20
1 to 3 Years	5	1	9	1	0	1
4 to 6 Years	5	0	4	1	0	0
7 to 12 Years	6	0	0	2	0	1
13 to 16 Years	6	1	0	3	7	2
17 to 18 Years	10	0	0	0	4	0
Over 18	0	0	0	0	0	0
Total	40	2	22	37	11	24
Male						
Black or African American	2	0	3	0	0	3
Asian	0	0	0	0	1	0
Hispanic	4	0	4	3	0	1
Native American	4	0	3	3	0	2
Other	0	0	0	1	0	0
Pacific Islander	2	0	0	0	0	0
Unknown	1	0	0	0	0	0
White	17	0	5	18	4	8
Total	30	0	15	25	5	14
Female						
Black or African American	1	0	2	2	0	1
Asian	0	0	0	1	0	0
Hispanic	0	0	2	2	1	2
Native American	2	0	1	0	0	2
Other	0	1	1	0	1	0
Pacific Islander	0	0	0	2	0	0
Unknown	1	0	1	2	0	0
White	9	0	6	8	5	8
Total	13	2	13	17	7	13

*Some children are in more than one race category

APPENDIX D

Official Manner of Death No Fatality Review Required N=53						
Age	Accidental	Homicide (3rd Party)	Homicide (by Abuse)	Natural	Suicide	Unknown
Up to 1 Year	1	0	4	10	0	6
1 to 3 Years	1	1	6	1	0	0
4 to 6 Years	4	0	3	0	0	0
7 to 12 Years	4	0	0	1	0	1
13 to 16 Years	1	1	0	1	1	2
17 to 18 Years	3	0	0	0	1	0
Over 18	0	0	0	0	0	0
Total	14	2	13	13	2	9
MALE						
Black or African American	1	0	3	0	0	1
Asian	0	0	0	0	0	0
Hispanic	2	0	4	1	0	1
Native American	0	0	0	0	0	1
Other	0	0	0	0	0	0
Pacific Islander	1	0	0	0	0	0
Unknown	1	0	0	0	0	0
White	6	0	2	7	1	4
Total	11	0	9	8	1	7
FEMALE						
Black or African American	0	0	1	2	0	1
Asian	0	0	0	0	0	0
Hispanic	0	0	2	0	0	1
Native American	1	0	0	0	0	0
Other	0		1	0	0	0
Pacific Islander	0	0	0	1	0	0
Unknown	1	1	1	1	0	0
White	3	1	5	2	1	2
Total	5	2	8	6	1	3

*Some children are in more than one category

APPENDIX D

2004 Official Manner of Death Fatality Review Required N=83						
Age	Accidental	Homicide (3rd Party)	Homicide (by Abuse)	Natural	Suicide	Unknown
Up to 1 Year	7	0	5	20	0	14
1 to 3 Years	4	0	3	0	0	1
4 to 6 Years	1	0	1	1	0	0
7 to 12 Years	2	0	0	1	0	0
13 to 16 Years	5	0	0	2	6	0
17 to 18 Years	7	0	0	0	3	0
Over 18	0	0	0	0	0	0
Total	26	0	9	24	9	15
MALE						
Black or African American	1	0	0	0	0	2
Asian	0	0	0	0	1	0
Hispanic	2	0	0	2	0	0
Native American	4	0	3	3	0	1
Other	0	0	0	1	0	0
Pacific Islander	1	0	0	0	0	0
Unknown	0	0	0	0	0	0
White	11	0	3	11	3	4
Total	17	0	6	17	4	7
FEMALE						
Black or African American	1	0	1	0	0	0
Asian	0	0	0	1	0	0
Hispanic	0	0	0	2	1	1
Native American	1	0	1	0	0	2
Other	0	0	0	0	1	0
Pacific Islander	0	0	0	1	0	0
Unknown	0	0	0	1	0	0
White	6	0	1	6	4	6
Total	8	0	3	11	6	9
*Some children are in more than one race category						